STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS	{G 000}		

This visit was a revisit for an extended Federal Home Health Complaint Survey completed on 02/24/14, 02/25/14, 02/26/14, 02/27/14, and 02/28/14 that resulted in an Immediate Jeopardy that was unremoved at exit. A survey conducted 4/3/14 found the Immediate Jeopardy was removed.

Complaint IN00145142 - Substantiated: Federal deficiencies related to the allegation are cited. Unrelated deficiencies are also cited.

Survey date: May 27 and 28, 2014

Facility: 003413

Medicaid Vendor: 200434910

Current Census: 21

Surveyor: Shannon Pietraszewski, RN, PHNS

Two (2) conditions and 39 standards were found to be corrected as a result of this survey. Six (6) conditions and 14 standard level deficiencies remain uncorrected and were recited. There were seven (7) new standards cited.

Valco Healthcare Services, Inc. is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years starting 5/28/14 due to being found out of compliance with Condition of Participation 42 CFR 484.14 Organization, Services, and Administration; 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 484.30 Nursing Services; 484.36 Home Health Aide

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	Continued From page 1 Services; 484.48 Clinical Records; and 484.55 Comprehensive Assessment of Patients. The Administrator / Director of Nursing was informed of this preclusion prior to the exit conference on 5/28/14 at 2:00 PM. Quality Review: Joyce Elder, MSN, BSN, RN June 3, 2014	{G 000}		
{G 110}	484.10(c)(2)(ii) RIGHT TO BE INFORMED AND PARTICIPATE The HHA complies with the requirements of Subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. The HHA must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable State law. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. This STANDARD is not met as evidenced by: Based on agency document and policy review and interview, the agency failed to ensure patients were provided the agency's Advance Directive policy in 1 of 1 admission packet reviewed with the potential to affect all patients of the agency. Findings include	{G 110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 110}	Continued From page 2 1. The admission packet given to the patients failed to include the agency's Advance Directive policy in the admission folder that was distributed to the patients at the start of care. 2. The Administrator / Director of Nursing and the Chief Executive Officer on 05/28/14 at 12:00 PM indicated they were not aware they needed to provide a copy of the agency's policy in the admission packet. 3. The agency document titled "Admission Documents" dated 08/22/11 states. "Pertinent information regarding the organization's policy on patient Advance Directives including a description of an individual's right under state law (whether statutory or as recognized by the courts of a state) and how such rights are implemented by the organization ... "	{G 110}		
G 120	484.12(b) DISCLOSURE OF OWNERSHIP & MANAGEMENT The HHA also must disclose the following information to the State survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management: (1) The name and address of all persons with an ownership or control interest in the HHA as defined in §§420.201,420.202, and 420.206 of this chapter. (2) The name and address of each person who is an officer, a director, an agent or a managing employee of the HHA as defined in §§420.201, 420.202, and 420.206 of this chapter.	G 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 120	Continued From page 3 (3) The name and address of the corporation, association, or other company that is responsible for the management of the HHA, and the name and address of the chief executive officer and the chairman of the board of directors of that corporation, association, or other company responsible for the management of the HHA. This STANDARD is not met as evidenced by: Based on agency document review and interview, the agency failed to ensure documentation regarding changes in administration were provided to ISDH (Indiana State Department of Health) creating the potential to affect all 21 patients who are receiving services from the agency. Findings include: 1. Review of the organizational chart on 05/27/14 at 3:00 PM evidenced employee QQ, a Registered Nurse, was the Assistant Director of Nursing. 2. The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 PM that employee D, bookkeeper / Human Resources, was supposed to have sent the paperwork to ISDH after the Professional Advisory Group meeting on 05/19/14.	G 120		
{G 122}	484.14 ORGANIZATION, SERVICES & ADMINISTRATION	{G 122}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 122}	Continued From page 4 This CONDITION is not met as evidenced by: Based on observation, record and policy review, and interview, the Administrator failed to be knowledgeable in order to organize and direct the agency's everyday functions and the staff creating the potential to affect all of the agency's 21 current patients (See G 133); the agency failed to ensure a qualified person was available to act in the absence of the administrator creating the potential to affect all of the agency's 21 current patients (See G 137); the agency failed to ensure their efforts were coordinated effectively with the dialysis personnel furnishing services for 2 of 2 records reviewed of patients receiving dialysis services from another provider creating the potential to affect all of the agency's patients that receive more than one service (See G 143); failed to ensure their efforts were coordinated and documented effectively with the dialysis personnel furnishing services for 2 of 2 records reviewed of patients receiving dialysis services from another provider creating the potential to affect all of the agency's patients that receive more than one service (See G 144). and failed to ensure the 60 day summary included all of a patient's condition changes that occured for 1 of 4 records reviewed creating the potential to affect all 21 patient's receiving services from the agency (See G 145). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this Condition of Participation 42 CFR 484.14 Organization, Services, and Administration.	{G 122}		
{G 133}	484.14(c) ADMINISTRATOR	{G 133}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 133}	Continued From page 5 The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on observation, record and policy review, and interview, the Administrator failed to be knowledgeable in order to organize and direct the agency's everyday functions and the staff creating the potential to affect all of the agency's 21 current patients. Findings include: 1. The Administrator, Registered Nurse / Director of Nursing, failed to ensure patients were provided the agency's Advance Directive policy. 2. The Administrator failed to ensure a qualified person was available to act in an emergency in the absence of the administrator. On 05/27/14 and 5/28/14, the current / listed Alternate Administrator was not observed in the agency. 3. The Administrator failed to ensure documentation regarding changes in administration was provided to Indiana State Department of Health in a timely manner. 4. The Administrator failed to ensure their efforts were coordinated and documented effectively with the dialysis personnel furnishing	{G 133}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 133}	Continued From page 6	{G 133}		

services.

5. The Administrator failed to ensure home health aide visits had been provided only as ordered by the physician and failed to ensure the plan of care had been followed in relation to physician notification.

6. The Administrator failed to ensure plans of care were revised and included all dialysis medications, fluid restrictions, outside meal service, new / old prescribed medications, and all durable medical equipment / supplies.

7. The Administrator failed to ensure the 60 day summary included all of a patient's condition changes that occurred.

8. The Administrator failed to notify and follow up with the physician in relation to elevated blood pressures.

9. The Administrator failed to ensure that new prescriptions were verified and written in a timely manner.

10. The Administrator failed to ensure that the home health aide care plan was following the plan of care.

11. Administrator failed to ensure the home health aide provided services as ordered by the physician.

12. The Administrator failed to ensure the registered nurse properly evaluated the home health aide during supervisory visits.

13. The Administrator failed to ensure the initial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 133}	Continued From page 7 assessment visit was held within 48 hours of a referral. 14. The Administrator failed to ensure comprehensive assessments were complete, accurate, and consistent with the patients needs. 15. The Administrator failed to ensure the medication profile was current and up to date.	{G 133}		
{G 137}	484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator. This STANDARD is not met as evidenced by: Based on observation and interview, the agency failed to ensure a qualified person was available to act in the administrator's creating the potential to affect all of the agency's 21 current patients. Findings include: 1. On 05/27/14, the current / listed Alternate Administrator was not observed in the agency. 2. On 05/28/14, the current / listed Alternate Administrator was not observed in the agency. 3. The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 PM the Alternate Administrator would come into the office once a week due to having another full time employment. The Administrator / Director of Nursing indicated the Alternate Administrator would do "whatever work that needs help with" but was usually OASIS data. The Administrator / Director of Nursing	{G 137}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 137}	Continued From page 8 indicated she was not sure if the Alternate Administrator could leave her full time employment should an emergency arise and she was needed.	{G 137}		
{G 143}	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure their efforts were coordinated effectively with the dialysis personnel furnishing services for 2 of 2 records reviewed of patients receiving dialysis services from another provider creating the potential to affect all of the agency's patients that receive more than one service . (# 2 and 11) Findings include: 1. Clinical record number 2, SOC (start of care) 05/05/14, included a plan of care established by the physician for certification period 05/05/14 to 07/03/14. The plan of care evidenced the patient was receiving dialysis three times a week. The clinical record failed to evidence communication and / or coordination of care with the dialysis facility in regards to the patient's dialysis medications, elevated blood pressures, diet, and fluid restrictions. The Dialysis center was contacted on 05/28/14 and returned the call on 05/29/14. The	{G 143}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 143}	Continued From page 9 Dietician from the dialysis center indicated on 05/29/14 that patient number 2 was on a renal diet and 1500 ml (milliliter) fluid restriction. 2. Clinical record number 11, SOC 04/30/14, included a plan of care established by the physician for certification period of 04/30/14 to 06/28/14. The plan of care evidenced the patient was receiving dialysis three times a week. The clinical record failed to evidence communication and / or coordination of care with the dialysis facility in regards to the patient dialysis medications. 3. The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 indicated she did not know if patient number 2 was on a fluid restriction or a renal diet and was not aware of the need to include dialysis medications on the plan of care and medication profile. At the time of the exit conference, the Administrator / Director of Nursing had not notified the dialysis center of patient number 2's medication. The Administrator / Director of Nursing indicated that coordination would take place on admission and every 60 days unless there was a need before the 60 days. 4. A policy titled "Coordination of Services With Other Providers" dated 08/22/11 stated, "A Case Manager will be assigned to be responsible for coordinating services provided to the patient by the organization, including services provided directly and through contract. The Case Manager will act as liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services."	{G 143}		
{G 144}	484.14(g) COORDINATION OF PATIENT SERVICES	{G 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 144}	Continued From page 10	{G 144}		

The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.

This STANDARD is not met as evidenced by:
Based on clinical record and policy review, and interview, the agency failed to ensure their efforts were coordinated and documented effectively with the dialysis personnel furnishing services for 2 of 2 records reviewed of patients receiving services from another provider creating the potential to affect all of the agency's patients that receive more than one service. (2 and 11)

Findings include:

1. Clinical record number 2, SOC (start of care) 05/05/14, included a plan of care established by the physician for certification period 05/05/14 to 07/03/14. The plan of care evidenced the patient was receiving dialysis three times a week. The clinical record failed to evidence communication and / or coordination of care with the dialysis facility in regards to the patient's dialysis medications, elevated blood pressures, diet, and fluid restrictions.

The Dialysis center was contacted on 05/28/14 and returned the call on 05/29/14. The Dietician from the dialysis center indicated on 05/29/14 that patient number 2 was on a renal diet and 1500 ml (milliliter) fluid restriction.

2. Clinical record number 11, SOC 04/30/14, included a plan of care established by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 144}	Continued From page 11 physician for certification period of 04/30/14 to 06/28/14. The plan of care evidenced the patient was receiving dialysis three times a week. The clinical record failed to evidence communication and / or coordination of care with the dialysis facility in regards to the patient dialysis medications. 3. The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 indicated she did not know if patient number 2 was on a fluid restriction or a renal diet and was not aware of the need to include dialysis medications on the plan of care and medication profile. At the time of the exit conference, the Administrator / Director of Nursing had not notified the dialysis center of patient number 2's medication. The Administrator / Director of Nursing indicated that coordination would take place on admission and every 60 days unless there was a need before the 60 days. 4. A policy titled "Coordination of Services With Other Providers" dated 08/22/11 stated, "A Case Manager will be assigned to be responsible for coordinating services provided to the patient by the organization, including services provided directly and through contract. The Case Manager will act as liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services."	{G 144}		
{G 145}	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by:	{G 145}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 145}	Continued From page 12	{G 145}		

Based on clinical record and policy review and interview, the agency failed to ensure the 60 day summary included all of a patient's condition changes that occured for 1 of 4 records reviewed creating the potential to affect all 21 patient's receiving services from the agency. (# 12)

Findings include:

1. Clinical record number 12 included a plan of care established by a physican for the certification period 05/20/14 to 07/18/14 for skilled nursing and home health aide services. The patient diagnoses included, but were not limited to, diabetes mellitus II, hypertension, cerebral arterial occlusion, and blind hypertensive eye.

a. The OASIS Admission Assessment dated 03/21/14 stated the patient had a brace on her foot upon admission.

b. A skilled nursing visit note dated 04/17/14 stated the patient had a blood pressure reading of 164/118 to the left arm and 168/119 to the right arm, gait disturbance due to a cast, and new medications prescribed due to hypertension.

c. A skilled nursing visit note dated 05/01/14 stated the patient had a blood pressure reading of 195/118, chest pain, numbness and tingling to the left arm, mobility problems, and chronic pain. The patient was instructed to go to the emergency room.

d. A clinical addendenum note dated 05/02/14 stated the patient had a blood pressure reading of 195/118, chest pain, numbness and tingling. The patient was instructed to go to the hospital for further evaluation. The addendum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 145}	Continued From page 13 also stated the patient reported a fall due to bad weather and had fallen down the stairs leading to the drive way and broken his/her left leg. During the emergency visit, the patient's leg was casted. e. A skilled nursing visit note dated 05/15/14 stated the patient had a blood pressure reading of 169/133. f. The 60 day summary failed to evidence the hypertensive episodes, new prescriptions, pain, brace, and fall with inury (cast). 2. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 05/28/14 at 12:00 PM. 3. A policy titled "60 Day Summary" dated 08/22/11 stated, "Information required in the 60-day summary report to the physician may include ... Reason for Admission or last recertification if applicable ... A summary of care and treatment / procedure provided ... A summary of the patient's response to treatment ... A summary of changes to the plan of care ... why recertification for ongoing care is necessary ... "	{G 145}		
{G 156}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure home health aide visits had been provided only as ordered by the physician and failed to ensure	{G 156}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 156}	Continued From page 14 the plan of care had been followed in relation to physician notification for 1 of 4 records reviewed creating the potential to affect all of the agency's 21 current patients (See G 158); failed to ensure plans of care were revised and included all dialysis medications, fluid restrictions, outside meal service, new / old prescribed medications, and all durable medical equipment / supplies for 3 of 4 records reviewed for patients receiving dialysis creating the potential to affect all of the agency's 21 current patients receiving services from the agency (See G 159); failed to notify and follow up with the physician in relation to changes in condition for 2 of 4 records reviewed creating to affect all 21 patients receiving services within the agency (See G 164); and failed to ensure that new prescriptions were clarified and written for 1 of 4 records reviewed creating the potential to affect all 21 patients receiving services from the agency (See G 166). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.18: Acceptance of Patients, Plan of Care, and Medical Supervision.	{G 156}		
{G 158}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure	{G 158}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 158}	Continued From page 15	{G 158}		

home health aide visits had been provided only as ordered by the physician and failed to ensure the plan of care had been followed in relation to physician notification for 1 of 4 records reviewed creating the potential to affect all of the agency's 21 current patients. (# 12)

The findings include:

1. Clinical record number 12, SOC 04/30/14, included a plan of care established by a physician for certification period 03/21/14 to 05/19/14 for skilled nursing 1 day a week every other week and home health aide services 4 hours a day 7 days a week. The plan of care stated the physician was to be notified for blood pressures less than 90/50 or greater than 180/100.

a. A skilled nursing visit note dated 05/15/15 evidenced the patient had a blood pressure of 169/133. The clinical record failed to evidence the physician was notified of the elevated blood pressure.

b. The clinical record failed to evidence a home health aide visit on 03/22/14, 03/23/14, and 03/26/14.

2. The Administrator / Director of Nursing indicated on 05/28/14 at 2:00 PM that she was not aware of the lack of physician notification.

3. A policy titled "Physician Participation in Plan of Care" dated 08/22/11 stated, "The attending physician will participate in the care planning process by initiating, reviewing and revising therapeutic and diagnostic orders. The care ill be provided in compliance with the therapeutic and diagnostic orders and accepted standards and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 158}	Continued From page 16 practice."	{G 158}		
{G 159}	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure plans of care were revised and included all dialysis medications and perma cath maintenance, fluid restrictions, outside meal service, new / old prescribed medications, and all durable medical equipment / supplies for 3 of 4 records reviewed for patients receiving dialysis creating the potential to affect all of the agency's 21 current patients receiving services from the agency. (# 2, 11 and 12) Findings include: 1. Clinical record number 2, SOC (start of care) 05/05/14, included a plan of care established by the physician for certification period of 05/05/14 to 07/03/14 for home health aide services. a. The comprehensive non-skilled assessment and care conference note dated 05/05/14 evidenced the patient was receiving	{G 159}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 159}	Continued From page 17	{G 159}		

dialysis three times a week and was receiving an outside service for meals. The plan of care failed to evidence dialysis medications, fluid restrictions, and outside service for meals.

b. The Dialysis center was contacted on 05/28/14 and returned the call on 05/29/14. The Dietician from the dialysis center indicated on 05/29/14 that patient number 2 was on a renal diet and 1500 ml (milliliter) fluid restriction. The Dietician also indicated the patient was not receiving [name of specific meal program] but was receiving breakfast and lunch through a different agency in the patient's apartment building.

2. Clinical record number 11, SOC 04/30/14, included a plan of care established by the physician for certification period of 4/30/14 to 06/28/14 for home health aide services.

a. The comprehensive non-skilled assessment and care conference note dated 04/30/14 evidenced the patient was receiving dialysis treatments 3 times a week, had a perma cath, and outside service for meals. The plan of care failed to include dialysis medications and that the patient was receiving perma cath maintenance and an outside service for meals.

b. The medication profile identified the patient was prescribed 750 mg (milligrams) of Keppra by mouth twice a day and 1000 mg by mouth on Monday / Wednesday / Friday. The plan of care medication list failed to include Keppra 750 mg by mouth twice a day.

3. Clinical record number 12, SOC 03/21/14, included a plan of care established by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 159}	Continued From page 18 physician for certification period of 03/21/14 to 05/19/14 and 05/20/14 to 07/18/14 with orders for skilled nursing services every other week for medication set up and home health aide services 4 hours a day 7 days a week for activities of daily living assistance. a. The plan of care dated 03/21/14 to 05/19/14 stated the patient had gloves and a life alert emergency system in the DME / supply section. The plan of care failed to be revised to include cane, insulin needles, glucometer and finger sticks, and an arm and leg brace. b. A physician order dated 05/13/14 indicated the patient was to start Klor-Con M20 20 meq (milliequivalent) 1 tab by mouth daily with food, Carvidolol 3.125 mg (milligrams) 2 tabs by mouth twice a day, hydrochlorothiazide 25 mg 1 tab by mouth daily, and nitroglycerin 0.4 mg 1 tab every 5 minutes, maximum 3 tabs as needed for chest pain. These medications were not included on the plan of care. 4. The Director of Nursing was unable to provide any additional documentation and / or information when asked on 05/28/14 at 12:00 PM. 5. A policy titled "Physician Participation in Plan of Care" dated 08/22/11 stated, "Physician ... orders will be individualized , based on patient's needs, and include ... B. Treatments and / or procedures needed, including type, frequency, duration, and goals ... Orders will be reviewed and revised by the patient's physician ... based on: Changes in diagnosis or treatment, including procedures, medications and equipment ... "	{G 159}		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF	G 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 164	Continued From page 19	G 164		

CARE

Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.

This STANDARD is not met as evidenced by:
Based on clinical record and policy review and interview, the agency failed to notify and follow up with the physician in relation to changes in condition for 2 of 4 records reviewed creating the potential to affect all 21 patients receiving services within the agency. (11 and 12)

Findings include:

1. Clinical record number 11 included a plan of care established by a physician for the certification period of 04/30/14 to 06/28/14 for home health aide services. The patient's diagnoses included, but were not limited to, end stage renal disease, chronic airway obstruction, hypertension, congestive heart failure, and arthropathy.

a. A Comprehensive Non-Skilled assessment dated 04/30/14 at 7:20 AM stated the patient was having episodes of nose bleeds, complaints of a productive cough, chronic pain at a pain level of 9.5 on a scale of 1 - 10 (10 being the worst) to the left shoulder and neck, frequent / daily headaches, and a poor appetite. The dialysis physician requested medication assistance through the agency. The clinical summary state the primary care physician had been notified of the assessment findings.

b. A Clinical Addendum note dated 05/01/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 164	Continued From page 20	G 164		

at 4:00 PM stated a call was placed to the primary care physician's office to follow up on the patient's pain to the left side of the neck and shoulder. A message was left on the voicemail.

c. Employee QQ indicated on 05/28/14 at 3:00 PM that she did not notify neither physician of the nose bleeds and headaches the patient was having, nor did she follow up with the physician after 05/01/14 regarding the pain to the left shoulder and neck. Employee QQ indicated the patient had a doctor's appointment in the near future and was going to rely on the patient to report her problems to the physician at that time.

2. Clinical record number 12 included a plan of care established by a physician for the certification period 03/21/14 to 05/19/14 for skilled nursing and home health aide services. The patient diagnoses included, but were not limited to, diabetes mellitus II, hypertension, cerebral arterial occlusion, and blind hypertensive eye.

A skilled nursing visit note dated 05/15/15 evidenced the patient had a blood pressure of 169/133. The clinical record failed to evidence the physician was notified of the elevated blood pressure.

3. A policy titled "Monitoring patient Response / Reporting to Physician" dated 08/22/11 stated, "Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient ... Based on the communication with the physician (or other authorized licensed independent practitioner), a verbal order will be obtained for any change in the plan of care and communicated to all appropriate team members to ensure that care is provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 164	Continued From page 21 according to the revised plan of care."	G 164		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on clinical record and interview, the agency failed to ensure that new prescriptions was clarified and written for 2 of 4 records reviewed creating the potential to affect all 21 patients receiving services from the agency. (# 2 and 12) Findings include: 1. Clinical record number 2, start of care 05/05/14, included a physician order dated 05/08/14 that stated to increase the amlodipine from 5 mg (milligrams) to 10 mg. The physician order failed to evidence route and frequency of dosage or that the nurse had called the doctor to clarify this information. 2. Clinical record number 12 included a skilled nurse visit note dated 04/17/14 that stated the patient was prescribed Carvidolol 3.125 mg (milligrams) 1 tab twice a day, Klor - Con M20 (potassium supplement) 20 meq (milliequivalent) ER (extended release) 1 tab daily with food, and hydrochlorothiazide 25 mg 1 tab daily. The record failed to evidence a verbal order for these	G 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 166	Continued From page 22 medications. The physician finally wrote the order 05/13/14. 3. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 05/28/14 at 12:00 PM. 4. A policy titled "Verification of Physician Orders" dated 08/22/11 stated, "An order or prescription will be verified when there is a question or discrepancy in the order / prescription and when the order is communicated by someone other than the physician or his / her agent. The order or transcription of a verbal order ... "	G 166		
{G 168}	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on clinical record and policy review and interview, the Registered Nurse failed to follow the plan of care in relation to physician notification for 1 of 4 records reviewed creating to affect all 21 patients receiving services within the agency (G 170); the Registered Nurse failed to ensure that the patient was regularly re-evaluated after being admitted to home health services for 1 of 4 records reviewed creating the potential to affect all 21 patients receiving services from the agency (G 172); the Registered Nurse failed to ensure plans of care were revised and included all dialysis medications and perma cath maintenance, fluid restrictions, outside meal service, new / old prescribed medications, and all durable medical equipment / supplies for 3 of 4 records reviewed for patients receiving dialysis creating the potential to affect all of the agency's	{G 168}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 168}	Continued From page 23 21 current patients (G 173); and the Registered Nurse failed to notify and follow up with the physician in relation to elevated blood pressures for 2 of 4 records reviewed and failed to coordinate care with a dialysis facility personnel furnishing services to ensure their efforts were coordinated effectively for 2 of 2 records reviewed of patients receiving services from another provider creating the potential to affect all of the agency's 21 patients that receive one or more services (G 176). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.30: Skilled Nursing Services.	{G 168}		
{G 170}	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on clinical record and policy review, the Registered Nurse failed to follow the plan of care in relation to physician notification for 1 of 4 records reviewed creating to affect all 21 patients receiving services within the agency (# 12). Findings include: 1. Clinical record number 12 included a plan of care established by a physician for the certification period 03/21/14 to 05/19/14 for skilled nursing and home health aide services. The plan of care indicated the MD would be notified of vital signs outside of the parameters of less than 90/50 and greater than 180/100. A skilled nursing	{G 170}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 170}	Continued From page 24 visit note dated 05/15/15 evidenced the patient had a blood pressure of 169/133. The clinical record failed to evidence the physician was notified of the elevated blood pressure. 2. A policy titled "Monitoring patient Response / Reporting to Physician" dated 08/22/11 stated, "Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient ... Based on the communication with the physician (or other authorized licensed independent practitioner), a verbal order will be obtained for any change in the plan of care and communicated to all appropriate team members to ensure that care is provided according to the revised plan of care."	{G 170}		
{G 173}	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on review of clinical record and policy and interview, the Registered Nurse failed to ensure plans of care were revised and included all dialysis medications and perma cath maintenance, fluid restrictions, outside meal service, new / old prescribed medications, and all durable medical equipment / supplies for 3 of 4 records reviewed for patients receiving dialysis creating the potential to affect all of the agency's 21 current patients. (# 2, 11 and 12) Findings include: 1. Clinical record number 2, SOC (start of care)	{G 173}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 173}	Continued From page 25 05/05/14, included a plan of care established by the physician for certification period of 05/05/14 to 07/03/14 for home health aide services. a. The comprehensive non-skilled assessment and care conference note dated 05/05/14 evidenced the patient was receiving dialysis three times a week and was receiving an outside service for meals. The plan of care failed to evidence the registered nurse had revised the plan of care to include dialysis medications, fluid restrictions, and outside service for meals. b. The Dialysis center was contacted on 05/28/14 and returned the call on 05/29/14. The Dietician from the dialysis center indicated on 05/29/14 that patient number 2 was on a renal diet and 1500 ml (milliliter) fluid restriction. The Dietician also indicated the patient was not receiving [name of specific meal program] but was receiving breakfast and lunch through a different agency in the patient's apartment building. 2. Clinical record number 11, SOC 04/30/14, included a plan of care established by the physician for certification period of 4/30/14 to 06/28/14 for home health aide services. a. The comprehensive non-skilled assessment and care conference note dated 04/30/14 evidenced the patient was receiving dialysis treatments 3 times a week, had a perma cath, and outside service for meals. The plan of care failed to evidence the registered nurse had revised the plan of care to include include dialysis medications and that the patient was receiving perma cath maintenance and an outside service for meals.	{G 173}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 173}	Continued From page 26	{G 173}		

b. The medication profile identified the patient was prescribed 750 mg (milligrams) of Keppra by mouth twice a day and 1000 mg by mouth on Monday / Wednesday / Friday. The plan of care failed to evidence the registered nurse had revised the plan of care to include to include Keppra 750 mg by mouth twice a day.

3. Clinical record number 12, SOC 03/21/14, included a plan of care established by the physician for certification period of 03/21/14 to 05/19/14 and 05/20/14 to 07/18/14 with orders for skilled nursing services every other week for medication set up and home health aide services 4 hours a day 7 days a week for activities of daily living assistance.

a. The plan of care dated 03/21/14 to 05/19/14 stated the patient had gloves and a life alert emergency system in the DME / supply section. The plan of care failed to evidence the registered nurse had revised the plan of care to include include cane, insulin needles, glucometer and finger sticks, and an arm and leg brace.

b. A physician order dated 05/13/14 indicated the patient was to start Klor-Con M20 20 meq (milliequivalent) 1 tab by mouth daily with food, Carvidolol 3.125 mg (milligrams) 2 tabs by mouth twice a day, hydrochlorothiazide 25 mg 1 tab by mouth daily, and nitroglycerin 0.4 mg 1 tab every 5 minutes, maximum 3 tabs as needed for chest pain. These medications were not included on the plan of care.

4. The Director of Nursing was unable to provide any additional documentation and / or information when asked on 05/28/14 at 12:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 173}	Continued From page 27 5. A policy titled "Physician Participation in Plan of Care" dated 08/22/11 stated, "Physician ... orders will be individualized , based on patient's needs, and include ... B. Treatments and / or procedures needed, including type, frequency, duration, and goals ... Orders will be reviewed and revised by the patient's physician ... based on: Changes in diagnosis or treatment, including procedures, medications and equipment ... "	{G 173}		
{G 176}	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on clinical record and policy review, and interview, the Registered Nurse failed to notify and follow up with the physician in relation to elevated blood pressures for 2 of 4 records reviewed and failed to coordinate care with a dialysis facility personnel furnishing services to ensure their efforts were coordinated effectively for 2 of 2 records reviewed of patients receiving dialysis services from another provider creating the potential to affect all of the agency's 21 patients that receive one or more services. (# 2, 11, and 12) Findings include: Related to notification of physician 1. Clinical record number 11 included a plan of	{G 176}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 176}	Continued From page 28	{G 176}		

care established by a physician for the certification period of 04/30/14 to 06/28/14 for home health aide services. The patient's diagnoses included, but were not limited to, end stage renal disease, chronic airway obstruction, hypertension, congestive heart failure, and arthropathy.

a. A Comprehensive Non-Skilled assessment dated 04/30/14 at 7:20 AM stated the patient was having episodes of nose bleeds, complaints of a productive cough, chronic pain at a pain level of 9.5 on a scale of 1 - 10 (10 being the worst) to the left shoulder and neck, frequent / daily headaches, and a poor appetite. The dialysis physician requested medication assistance through the agency. The clinical summary state the primary care physician had been notified of the assessment findings.

b. A Clinical Addendum note dated 05/01/14 at 4:00 PM stated a call was placed to the primary care physician's office to follow up on the patient's pain to the left side of the neck and shoulder. A message was left on the voicemail.

c. Employee QQ indicated on 05/28/14 at 3:00 PM that she did not notify neither physician of the nose bleeds and headaches the patient was having, nor did she follow up with the physician after 05/01/14 regarding the pain to the left shoulder and neck. Employee QQ indicated the patient had a doctor's appointment in the near future and was going to rely on the patient to report her problems to the physician at that time.

2. Clinical record number 12 included a plan of care established by a physician for the certification period 03/21/14 to 05/19/14 for skilled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 176}	Continued From page 29	{G 176}		

nursing and home health aide services. The patient diagnoses included, but were not limited to, diabetes mellitus II, hypertension, cerebral arterial occlusion, and blind hypertensive eye.

A skilled nursing visit note dated 05/15/15 evidenced the patient had a blood pressure of 169/133. The clinical record failed to evidence the physician was notified of the elevated blood pressure.

3. A policy titled "Monitoring patient Response / Reporting to Physician" dated 08/22/11 stated, "Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient ... Based on the communication with the physician (or other authorized licensed independent practitioner), a verbal order will be obtained for any change in the plan of care and communicated to all appropriate team members to ensure that care is provided according to the revised plan of care."

Related to coordination of care

1. Clinical record number 2, SOC (start of care) 05/05/14, included a plan of care established by the physician for certification period 05/05/14 to 07/03/14. The plan of care evidenced the patient was receiving dialysis three times a week. The clinical record failed to evidence communication and / or coordination of care with the dialysis facility in regards to the patient's dialysis medications, elevated blood pressures, diet, and fluid restrictions.

The Dialysis center was contacted on 05/28/14 and returned the call on 05/29/14. The Dietician from the dialysis center indicated on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 176}	Continued From page 30 05/29/14 that patient number 2 was on a renal diet and 1500 ml (milliliter) fluid restriction. 2. Clinical record number 11, SOC 04/30/14, included a plan of care established by the physician for certification period of 04/30/14 to 06/28/14. The plan of care evidenced the patient was receiving dialysis three times a week. The clinical record failed to evidence communication and / or coordination of care with the dialysis facility in regards to the patient dialysis medications. 3. The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 indicated she did not know if patient number 2 was on a fluid restriction or a renal diet and was not aware of the need to include dialysis medications on the plan of care and medication profile. At the time of the exit conference, the Administrator / Director of Nursing had not notified the dialysis center of patient number 2's medication. The Administrator / Director of Nursing indicated that coordination would take place on admission and every 60 days unless there was a need before the 60 days. 4. A policy titled "Coordination of Services With Other Providers" dated 08/22/11 stated, "A Case Manager will be assigned to be responsible for coordinating services provided to the patient by the organization, including services provided directly and through contract. The Case Manager will act as liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services."	{G 176}		
{G 202}	484.36 HOME HEALTH AIDE SERVICES	{G 202}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 202}	Continued From page 31 This CONDITION is not met as evidenced by: Based on clinical record and policy review and interview, it was determined the agency failed to ensure that the home health aide care plan was following the plan of care for 3 of 3 records reviewed of patients receiving home health aide services and failed to include specialty diet and fluid restrictions to the home health aide care plans for 2 of 2 records reviewed of patients receiving dialysis and receiving home health aide assistance with meals creating the potential to affect all of the agency's current patients who were receiving home health aide services (See G 124); failed to ensure the home health aide provided services as ordered by the physician in 1 of 10 records reviewed creating the potential to affect all of the agency's current patients receiving home health aide services (See G 125); and failed to ensure the registered nurse properly evaluated the home health aide for 1 of 3 records reviewed of patients who were receiving home health aide services creating the potential to affect all of the agency's current patients receiving home health aide services (See G 129). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.36: Home Health Aide Services.	{G 202}		
{G 224}	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.	{G 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 224}	Continued From page 32	{G 224}		

This STANDARD is not met as evidenced by:
Based on clinical record and policy review and interview, the agency failed to ensure that the home health aide care plan was following the plan of care for 3 of 3 records reviewed of patients receiving home health aide services and failed to include specialty diet and fluid restrictions to the home health aide care plans for 2 of 2 records reviewed of patients receiving dialysis and receiving home health aide assistance with meals creating the potential to affect all of the agency's current patients who were receiving home health aide services. (# 2, 11, and 12).

Findings include:

1. Clinical record number 2, SOC (start of care) 05/05/14, included a plan of care established by a physician 05/05/14 to 07/03/14 for home health aide services 2 hours in the morning and 2 hours in the evening 7 days a week. The home health aide was to perform / assist with bathing, dressing, hair care, shampoo, skin care, foot care, check pressure areas, oral care, assist with elimination, medication reminders, assist with ambulation / mobility related to walker, wheelchair, transfers to chair, bed, commode, shower / tub, dangle, assist with light meal prep and set - up, laundry, light housekeeping, maintain clean and safe environment, and report any noted malfunctions of durable medical equipment as needed.

a. The morning home health aide care plan dated 05/05/14 identified the home health aide was to provide a shower, hair care / comb hair, oral care, skin care, peri care, assist with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 224}	Continued From page 33	{G 224}		

dressing, medication reminder, incontinence care, assist with transfer, light housekeeping, and meal set up every visit. The home health aide care plan failed to evidence the patient was on a renal diet and fluid restriction.

b. The evening home health aide care plan dated 05/05/14 identified the home health aide was to provide hair care / comb hair, oral care, skin care, peri care, assist with dressing, medication reminder, incontinence care, assist with transfer, light housekeeping, and meal set up every visit. The home health aide care plan failed to evidence the patient was on a renal diet and fluid restriction.

2. Clinical record number 11, SOC 04/30/14, included a plan of care established by a physician 04/30/14 to 06/28/14 for home health aide services for 3 hours per day, 3 days a week for 9 weeks. The home health aide was to perform / assist with bathing, dressing, hair care, shampoo, skin care, foot care, nail care, oral care, medication reminders, mobility assist with wheelchair, walker, cane, standby assist with shower, assist with light meal prep and set up, limit fluids to 6 cups / day, light housekeeping, maintain clean and safe environment, and report any noted malfunctions of durable medical equipment.

The home health aide care plan dated 4/30/14 identified the home health aide was to provide a tub bath, skin care, peri care, medication reminder, record bowel movement, dangle on side of bed, equipment care, make bed, and light housekeeping every visit. The home health aide was to change linen weekly and was to provide shampoo hair, hair care / comb

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 224}	Continued From page 34	{G 224}		

hair, nail care, oral care, assist with dressing, assist with transfer, assist with ambulation, and meal set up as needed. The home health aide care plan failed to evidence the patient was on a renal diet and fluid restriction.

3. Clinical record number 12, SOC 03/21/14, included a plan of care established by a physician 03/21/14 to 05/19/14 for home health aide services 4 hours a day 7 days a week. The plan of care stated the home health aide was to perform / assist with bathing, dressing, hair care, shampoo, skin care, check pressure areas, oral care, medication reminders, mobility with cane, mobility with tub / shower, and assist with light meal prep and light housekeeping.

The home health aide care plan dated 03/21/14 stated the home health aide was to provide a shower with chair, shampoo hair, hair care / comb hair, oral care, skin care, peri care, nail care, assist with dressing, equipment care, make bed, light housekeeping, and meal set up every visit and to provide a tub bath, assist with ambulation, and change linen as needed.

4. Review of the PAG (Professional Advisory Group) meeting minutes dated 05/19/14, the PAG agreed on a new home health aide care plan that was to be implemented by 05/23/14.

5. The Administrator / Director of Nursing indicated on 05/28/14 at 2:00 PM that the home health aide care plans do not have the same identifiable duties as the visit records and was recommended by the consultant to change to forms. The new forms for home health aide care plans was not implemented on 05/23/14. The Administrator / Director of Nursing indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 224}	Continued From page 35 office staff wasn't sure on how to implement the new form in the record and educate the new staff. The Chief Executive Office indicated the staff would be inserviced as they come in to turn in paperwork or to pick up pay checks. 6. A policy titled "Home Health Aide Plan of Care" dated 08/22/11 stated "The patient's Case Manager, upon initialization of aide services, will develop the home health aide plan of care, consistent with the comprehensive plan of care and physician (or other authorized licensed independent practitioner) orders ... "	{G 224}		
{G 225}	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure the home health aide provided services as ordered by the physician in 3 of 3 records reviewed of patients receiving home health aide services creating the potential to affect all of the agency's current patients receiving home health aide services. (#2, 11, and 12) Findings include: 1. Clinical record number 2, SOC (start of care) 05/05/14, included a plan of care established by a physician 05/05/14 to 07/03/14 for home health	{G 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 36	{G 225}		

aide services 2 hours in the morning and 2 hours in the evening 7 days a week.

a. The morning home health aide care plan dated 05/05/14 identified the home health aide was to provide a shower, hair care / comb hair, oral care, skin care, peri care, assist with dressing, medication reminder, incontinence care, assist with transfer, light housekeeping, and meal set up every visit. The home health aide care plan failed to evidence the patient was on a renal diet and fluid restriction.

The home health aide visit record dated 05/06/14 to 05/16/14 stated the home health aide encouraged fluids, assisted with the wheelchair, and "routine maintenance" with elimination. The clinical record failed to evidence that dressing, shampoo, foot care, checked pressure areas, incontinence care, meal set up, laundry, and light housekeeping were provided for the patient.

b. The evening home health aide care plan dated 05/05/14 identified the home health aide was to provide hair care / comb hair, oral care, skin care, peri care, assist with dressing, medication reminder, incontinence care, assist with transfer, light housekeeping, and meal set up every visit. The home health aide care plan failed to evidence the patient was on a renal diet and fluid restriction.

The home health aide visit record dated 05/06/14 to 05/16/14 stated the home health aide encouraged fluids, assisted with the wheelchair, "routine maintenance" with elimination. The clinical record failed to evidence that hair care / comb hair, oral care, skin care, peri care, assist with dressing, incontinence care, light

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 37 housekeeping, and meal set up. 2. Clinical record number 11, SOC 04/30/14, included a plan of care established by a physician 04/30/14 to 06/28/14 for home health aide services for 3 hours per day, 3 days a week for 9 weeks. The home health aide care plan dated 4/30/13 identified the home health aide was to provide a tub bath, skin care, peri care, medication reminder, record bowel movement, dangle on side of bed, equipment care, make bed, and light housekeeping every visit. The home health aide was to change linen weekly and was to provide shampoo hair, hair care / comb hair, nail care, oral care, assist with dressing, assist with transfer, assist with ambulation, and meal set up as needed. a. The home health aide visit record dated 05/03/14 failed to evidence a tub bath, shampoo, skin care, peri care, record of bowel movement, dangle on side of bed, equipment care, make bed, and light housekeeping had been provided. b. The home health aide visit record dated 05/06/13 failed to evidence a tub bath, shampoo, skin care, peri care, record of bowel movement, dangle on side of bed, equipment care, make bed, and light housekeeping had been provided. c. The home health aide visit record dated 05/08/14 failed to evidence the home health aide assisted with meal prep, provided peri care, shampoo, record of bowel movement, dangle on side of bed, equipment care, make bed, and light housekeeping had been provided. d. The home health aide visit record dated 05/10/14 and 05/13/14 failed to evidence	{G 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 38	{G 225}		

shampoo, skin care, peri care, dangle on side of bed, equipment care, make bed, and light housekeeping had been provided.

e. An updated home health aide care plan dated 05/15/15 stated the home health aide was to provide a shower with the shower chair, oral care, skin care, peri care, assist with dressing, medication reminder, record bowel movements, dangle on side of bed, make bed, light house keeping and meal set up every visit. The care plan also indicated the home health aide was to provide incontinence care, turn and position, assist with transfer, assist with ambulation, equipment care, make bed, and change linen prn (as needed).

The home health aide visit record dated 05/15/14 failed to evidence dangle on side of bed, make bed, light housekeeping, and medication reminder had been provided.

3. Clinical record number 12, SOC 03/21/14, included a plan of care established by a physician dated 03/21/14 to 05/19/14 for skilled nursing 1 day a week every other week and home health aide services 4 hours a day 7 days a week. The home health aide care plan dated 03/21/14 evidenced the home health aide was to provide a shower with chair, shampoo hair, hair care / comb hair, oral care, skin care, peri care, nail care, assist with dressing, equipment care, make bed, light housekeeping, and meal set up every visit and to provide a tub bath, assist with ambulation, and change linen as needed.

a. The home health aide visit record dated 03/21/14 evidence the home health aide encouraged fluids, provided range of motion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 39	{G 225}		

exercises, and medication reminder. The visit record failed to evidence that a shower was provided, shampoo hair, hair care / comb hair, oral care, nail care, equipment care, and light housekeeping was provided.

b. The home health aide visit records dated 03/24/14, 03/26/14, and 03/28/14 evidenced the home health aide encouraged fluids, provided range of motion exercises, assisted with a physician's appointment (03/24/14), and medication reminder. The clinical record failed to evidence the home health aide provided a shower, nail care, oral care, and light housekeeping.

c. The home health aide visit records dated 03/25/14 and 03/27/14 evidenced the home health aide encouraged fluids and completed a bed bath. The visit record failed to evidence nail care and light housekeeping.

d. The home health aide visit record dated 03/27/14 evidenced the home health aide encouraged fluids and provided medication reminder. The visit record failed to evidence meal prep, skin care, shampoo hair, hair care / comb hair, oral care, skin care, peri care, nail care, assist with dressing, equipment care, and light housekeeping was provided.

e. The home health aide visit records dated 03/29/14, 03/30/14, 04/01/14, and 04/03/14 evidenced the home health aide encouraged fluids and assisted with medication reminders. The visit record failed to evidence meal prep, shower, skin care, shampoo hair, hair care / comb hair, assistance with dressing, and light housekeeping.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 40	{G 225}		

f. The home health aide visit records dated 03/31/14, 04/02/14, and 04/04/14 evidenced the home health aide encouraged fluids, range of motion exercises, physician appointment (03/31/14), and medication reminders. The visit record failed to evidence nail care, oral care, and light housekeeping.

g. The home health aide visit records dated 04/05/14, 04/06/14, 04/08/14, and 04/10/14 evidenced the home health aide encouraged fluids and a provided medication reminders. The visit record failed to evidence meal prep, shower, skin care, shampoo hair, hair care / comb hair, nail care, skin care, oral care, assistance with dressing, and light housekeeping.

h. The home health aide visit records dated 04/07/14, 04/09/14, and 04/11/14 evidenced the home health aide encouraged fluids, range of motion exercises, physician appointment (04/07/14), and medication reminders. The clinical record failed to evidence nail care, oral care, and light housekeeping.

i. The home health aide visit record dated 04/13/14 evidenced the home health aide encouraged fluids, assistance with appliances / routine maintenance, and medication reminders. The visit record failed to evidence skin care, shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

j. The home health aide visit records dated 04/12/14, 04/15/14, and 04/17/14 evidenced the home health aide encouraged fluids and provided medication reminders. The clinical record failed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 41	{G 225}		

to evidence meal prep, skin care, shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

k. The home health aide visit records dated 04/14/14, 04/16/14, and 04/18/14 evidenced the home health aide encouraged fluids, range of motion exercises, and medication reminders. The visit record failed to evidence shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

l. The home health aide visit records dated 04/19/14 and 04/24/14 evidenced the home health aide encouraged fluids, back rub (04/19/14) provided assistance with appliances / routine maintenance, and medication reminders. The visit record failed to evidence skin care (04/19/14), shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

m. The home health aide visit records dated 04/19/14, 04/20/14, 04/22/14, and 04/24/14 evidenced the home health aide provided medication reminders. The clinical record failed to evidence meal prep (04/19/14, 04/20/14, 04/22/14), skin care, shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

n. The home health aide visit records dated 04/20/14 and 04/22/14 evidenced the home health aide encouraged fluids. The visit record failed to evidence skin care, shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

o. The home health aide visit records dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 42	{G 225}		

04/21/14, 04/23/14, and 04/25/14 evidenced the home health aide encouraged fluids, range of motion exercises, physician appointment (04/21/14), and medication reminders. The visit record failed to evidence a shower, shampoo care, hair care / comb hair, nail care, oral care, and light housekeeping.

p. The home health aide visit records dated 04/27/14 and 04/29/14 failed to evidence meal prep, shampoo hair, nail care, oral care, and light housekeeping.

q. The home health aide visit records dated 04/28/14 and 04/30/14 evidenced the home health aide encouraged fluids, range of motion exercises, and medication reminders. The visit record failed to evidence shampoo care, hair care / comb hair, nail care, oral care, and light housekeeping.

r. The home health aide visit records dated 05/01/14 and 05/02/14 evidenced the home health aide encouraged fluids and medication reminders. The visit record failed to evidence a shower, skin care, shampoo hair, hair care / comb hair, nail care, oral care, and light housekeeping.

s. The home health aide visit visit records dated 05/03/14 and 05/08/14 evidenced the home health aide encouraged fluids, assisted with appliances / routine maintenance, and medication reminders. The clinical record failed to evidence a shower, skin care, shampoo hair, hair care / comb hair, nail care, oral care, and light housekeeping.

t. The home health aide visit records dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 43	{G 225}		

05/04/14 and 05/06/14 evidenced the home health aide encouraged fluids, assisted with toileting, and provided medication reminders. The visit record failed to evidence meal prep, nail care, assistance with dressing, and light housekeeping.

u. The home health aide visit records dated 05/05/14, 05/07/14, and 05/09/14 evidenced the home health aide encouraged fluids, range of motion exercises, physician appointment (05/05/14), and medication reminders. The visit record failed to evidence a shower, shampoo hair, hair care / comb hair, nail care, and light housekeeping.

4. The PAG (Professional Advisory Group) meeting minutes dated 05/19/14 identified the PAG agreed on a new home health aide care plan that was to be implemented by 05/23/14.

5. The Administrator / Director of Nursing indicated on 05/28/14 at 2:00 PM that the home health aide care plans do not have the same identifiable duties as the visit records and was recommended by the consultant to change to forms. The new forms for home health aide care plans was not implemented on 05/23/14. The Administrator / Director of Nursing indicated the office staff wasn't sure on how to implement the new form in the record and educate the new staff. The Chief Executive Office indicated the staff would be inserviced as they come in to turn in paperwork or to pick up pay checks.

6. A policy titled "Home Health Aide Plan of Care" dated 08/22/11 stated "Each patient receiving home health aide services will have an individualized plan developed by an appropriate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 225}	Continued From page 44 professional and utilized to direct the care performed by the assigned aide ... The Case Manager or other appropriate clinician will supervise the home health aide ... to ensure care is provided according to plan."	{G 225}		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure the registered nurse properly evaluated the home health aide for 1 of 3 records reviewed of patients who were receiving home health aide services creating the potential to affect all of the agency's current patients receiving home health aide services. (# 12) Findings include: 1. Clinical record number 12, start of care 03/21/14, included a plan of care established by a physician dated 03/21/14 to 05/19/14 for skilled nursing 1 day a week every other week and home health aide services 4 hours a day 7 days a week. The home health aide care plan dated 03/21/14 evidenced the home health aide was to provide a shower with chair, shampoo hair, hair care / comb hair, oral care, skin care, peri care, nail care, assist with dressing, equipment care, make bed, light housekeeping, and meal set up every visit and to provide a tub bath, assist with ambulation, and change linen as needed.	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 45	G 229		

a. The home health aide visit record dated 03/21/14 evidence the home health aide encouraged fluids, provided range of motion exercises, and medication reminder. The visit record failed to evidence that a shower was provided, shampoo hair, hair care / comb hair, oral care, nail care, equipment care, and light housekeeping was provided.

b. The home health aide visit records dated 03/24/14, 03/26/14, and 03/28/14 evidenced the home health aide encouraged fluids, provided range of motion exercises, assisted with a physician's appointment (03/24/14), and medication reminder. The clinical record failed to evidence the home health aide provided a shower, nail care, oral care, and light housekeeping.

c. The home health aide visit records dated 03/25/14 and 03/27/14 evidenced the home health aide encouraged fluids and completed a bed bath. The visit record failed to evidence nail care and light housekeeping.

d. The home health aide visit record dated 03/27/14 evidenced the home health aide encouraged fluids and provided medication reminder. The visit record failed to evidence meal prep, skin care, shampoo hair, hair care / comb hair, oral care, skin care, peri care, nail care, assist with dressing, equipment care, and light housekeeping was provided.

e. The home health aide visit records dated 03/29/14, 03/30/14, 04/01/14, and 04/03/14 evidenced the home health aide encouraged fluids and assisted with medication reminders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 46	G 229		

The visit record failed to evidence meal prep, shower, skin care, shampoo hair, hair care / comb hair, assistance with dressing, and light housekeeping.

f. The home health aide visit records dated 03/31/14, 04/02/14, and 04/04/14 evidenced the home health aide encouraged fluids, range of motion exercises, physician appointment (03/31/14), and medication reminders. The visit record failed to evidence nail care, oral care, and light housekeeping.

g. The home health aide visit records dated 04/05/14, 04/06/14, 04/08/14, and 04/10/14 evidenced the home health aide encouraged fluids and a provided medication reminders. The visit record failed to evidence meal prep, shower, skin care, shampoo hair, hair care / comb hair, nail care, skin care, oral care, assistance with dressing, and light housekeeping.

h. The home health aide visit records dated 04/07/14, 04/09/14, and 04/11/14 evidenced the home health aide encouraged fluids, range of motion exercises, physician appointment (04/07/14), and medication reminders. The clinical record failed to evidence nail care, oral care, and light housekeeping.

i. The home health aide visit record dated 04/13/14 evidenced the home health aide encouraged fluids, assistance with appliances / routine maintenance, and medication reminders. The visit record failed to evidence skin care, shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 47	G 229		

j. The home health aide visit records dated 04/12/14, 04/15/14, and 04/17/14 evidenced the home health aide encouraged fluids and provided medication reminders. The clinical record failed to evidence meal prep, skin care, shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

k. The home health aide visit records dated 04/14/14, 04/16/14, and 04/18/14 evidenced the home health aide encouraged fluids, range of motion exercises, and medication reminders. The visit record failed to evidence shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

l. The home health aide visit records dated 04/19/14 and 04/24/14 evidenced the home health aide encouraged fluids, back rub (04/19/14) provided assistance with appliances / routine maintenance, and medication reminders. The visit record failed to evidence skin care (04/19/14), shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

m. The home health aide visit records dated 04/19/14, 04/20/14, 04/22/14, and 04/24/14 evidenced the home health aide provided medication reminders. The clinical record failed to evidence meal prep (04/19/14, 04/20/14, 04/22/14), skin care, shampoo care, hair care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

n. The home health aide visit records dated 04/20/14 and 04/22/14 evidenced the home health aide encouraged fluids. The visit record failed to evidence skin care, shampoo care, hair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 48	G 229		

care / comb hair, nail care, oral care, assistance in dressing, and light housekeeping.

o. The home health aide visit records dated 04/21/14, 04/23/14, and 04/25/14 evidenced the home health aide encouraged fluids, range of motion exercises, physician appointment (04/21/14), and medication reminders. The visit record failed to evidence a shower, shampoo care, hair care / comb hair, nail care, oral care, and light housekeeping.

p. The home health aide visit records dated 04/27/14 and 04/29/14 failed to evidence meal prep, shampoo hair, nail care, oral care, and light housekeeping.

q. The home health aide visit records dated 04/28/14 and 04/30/14 evidenced the home health aide encouraged fluids, range of motion exercises, and medication reminders. The visit record failed to evidence shampoo care, hair care / comb hair, nail care, oral care, and light housekeeping.

r. The home health aide visit records dated 05/01/14 and 05/02/14 evidenced the home health aide encouraged fluids and medication reminders. The visit record failed to evidence a shower, skin care, shampoo hair, hair care / comb hair, nail care, oral care, and light housekeeping.

2. The home health aide supervisory visit note dated 05/01/14 indicated the home health aide implemented the home health aide plan of care and performed assigned tasks per standard care protocol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 229	Continued From page 49 3. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 05/28/14 at 12:00 PM.	G 229		
{G 235}	484.48 CLINICAL RECORDS This CONDITION is not met as evidenced by: Based on clinical record and policy review and interview, it was determined the agency failed to ensure clinical records contained accurate and complete documents in accordance with accepted professional standards for 3 of 4 records reviewed creating the potential to affect all 21 current patients receiving services (See G 236). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.48: Clinical Records.	{G 235}		
{G 236}	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by:	{G 236}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 236}	Continued From page 50	{G 236}		

Based on clinical record and policy review and interview, the agency failed to ensure clinical records contained accurate and complete documents in accordance with accepted professional standards for 3 of 4 records reviewed creating the potential to affect all 21 current patients receiving services. (# 2, 11, and 12)

Findings include:

1. Clinical record number 2, start of care (SOC) 05/05/14, evidenced an incomplete referral form that failed to evidence when the referral was obtained.

The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 PM that the patient was a self referral and the referral form should have had a signature and date of when the referral was obtained.

2. Clinical record number 11, SOC 04/30/14, included a Comprehensive Non-Skilled Admission Assessment dated 4/30/14 that was incomplete and inaccurate. The assessment failed to indicate the reason for home health services; evidenced the patient had blurred vision but failed to evidence how the impaired vision interfered / impacted the patient's function / safety; pulmonary assessment evidenced the patient was receiving oxygen via nasal cannula at 3 liters per minute as needed but failed to evidence if there was humidification with the oxygen (nose assessment indicated the patient was having frequent nose bleeds) and failed to include intermittent treatments (duonebs nebulizer breathing treatments, albuterol inhalers, and flonase to each nostril); cardiac assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 236}	Continued From page 51	{G 236}		

failed to indicate if the patient had demonstrated / verbalized compliance with health education provided and the plan of care; nutritional assessment failed to evidence a weight and diet (renal diet), appetite was checked off as being "fair" but disease management stated, "Appetite poor;" neuro / emotional / behavior assessment failed to evidence the patient was receiving an antidepressant (paxil), the dose and frequency; safety measures had a diagonal line through the section and failed to indicate bleeding and fall precautions as well as walker / cane; allergies section was left blank; and failed to indicate if the patient had oxygen back up.

3. Clinical record number 12 included an incomplete referral form that failed to evidence referral source and information, other services involved in care, and incomplete patient information.

a. A clinical addendum note dated 03/21/14 failed to evidence the date and time the physician was notified of the assessment findings.

b. The OASIS Admission Assessment dated 03/21/14 failed to evidence the patient's name and identification number on pages 2 to 20. The assessment included an incomplete history and diagnoses, no indication of advance directives, incomplete Integumentary status, incomplete cardiopulmonary assessment, incomplete nutritional assessment, a musculoskeletal assessment, and appliances / special equipment.

c. The OASIS Recertification Assessment dated 05/15/14 failed to evidence the patient's name and identification number on pages 2 to 14, physician identification, demographics, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 236}	Continued From page 52 episode timing. The assessment contained an incomplete Integumentary status assessment, cardiopulmonary assessment, endocrine assessment, fall risk assessment, amplification of care provided / analysis of findings, summary, and care summary 4. The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 PM that she is aware of the nurses assessment errors. The Administrator / Director of Nursing indicated employee H had turned in her notice and was not available for an interview for clarifications of assessments and documentation. 5. A policy titled "Contents of Clinical Record" dated 08/22/11 stated, "The clinical record will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among organization and contract personnel."	{G 236}		
{G 330}	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the	{G 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 330}	Continued From page 53 Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary This CONDITION is not met as evidenced by: Based on clinical record and policy review and interview, it was determined the agency failed to ensure the initial assessment visit was held within 48 hours of a referral for 1 of 4 patients reviewed creating the potential for affect all of the agency's 21 current patients receiving services (See G 333); failed to ensure comprehensive assessments were complete, accurate, and consistent with the patients needs within 5 days after the start of care for 3 of 4 records reviewed creating the potential to affect all 21 patients receiving services within the agency (See G 334); and failed to ensure the medication profile was current and up to date for 2 of 4 records reviewed creating the potential to affect all of the agency's 21 current patients receiving services (See G 337). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the Condition of Participation 484.55: Comprehensive Assessment of Patients.	{G 330}		
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the	G 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 332	Continued From page 54 physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure the initial assessment visit was held within 48 hours of a referral for 1 of 4 records reviewed creating the potential to affect all of the agency's new patients. (# 2) Findings include: 1. Clinical record number 2, start of care 05/05/14, evidence an incomplete referral form that failed to evidence when the referral was obtained. Therefore, it could not be determined if the initial assessment visit was completed timely. The Administrator / Director of Nursing indicated on 05/28/14 at 12:00 PM the patient was a self referral and the referral form should have had a signature and date of when the referral was obtained. 2. A policy titled "Initial & Comprehensive Assessments" dated 08/22/11 stated, "The initial assessment visit must be performed either within 48 hours of the referral ... "	G 332		
G 334	484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. This STANDARD is not met as evidenced by:	G 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 334	Continued From page 55	G 334		

Based on clinical record and policy review and interview, the agency failed to ensure comprehensive assessments were complete, accurate, and consistent with the patient's needs for 3 of 4 records reviewed creating the potential to affect all 21 patients receiving services within the agency. (# 2, 11, and 12)

Findings include:

1. Clinical record number 2, SOC 05/05/14, included a Comprehensive Non-skilled Assessment dated 05/05/14, that was found to be incomplete and inaccurate. The patient history was incomplete and failed to indicate the patient's surgical history, immunizations, and dates and reasons for hospitalizations (patient was a new dialysis patient and has had multiple hospitalizations in the past 6 months). The assessment stated the reason for the visit was "asthma attack" (no order to indicate reason for admission) but the referral / intake form had stated end stage renal disease. The mental status was checked as "oriented," lung sounds were not assessed on pulmonary assessment, blood pressure was 232/89 but the cardiac assessment was checked "no problem" without assessment of the heart, endocrine assessment and diabetic foot exam incomplete, nutritional assessment failed to indicate renal diet and fluid restrictions but inaccurately indicated the patient was set up on "meals on wheels" and to drink plenty of water and adhere to a healthy diet consisting of the four basic food groups. The psychosocial was checked "no problem" but stated the patient had missed medication doses. The genitourinary, elimination, and skin / wound / ostomy section failed to indicate the patient had urinary incontinence and a colostomy appliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 334	Continued From page 56	G 334		

as it was indicated in the home health aide care plan, musculoskeletal assessment incomplete as it was indicated "no change," and fall risk assessment failed to include age, incontinence, and cognitive impairment. Assessment of Risk Factors for re-hospitalization and emergent care failed to indicate urinary incontinence, confusion, 10 or more medications, and ADL (activities of daily living). Safety measures failed to include bleeding precautions as the patient received heparin during dialysis and was also prescribed plavix 75 mg (milligrams) daily. Medication assessment indicated "no changes" since last assessment when there was a change in blood pressure medication. Education provided were "Don't stop meds (medications) abruptly" and "Don't miss dialysis appointments."

a. The Administrator / Director of Nursing indicated the registered nurse responsible for the admission assessment would no longer be doing admissions and was not able to indicate if the patient was on a renal diet or fluid restriction. The Administrator / Director of Nursing indicated the patient had been hospitalized and the patient was a self referral and she (Administrator / Director of Nursing) did not obtain the recent hospital records.

b. The Dialysis center was contacted on 05/28/14 and returned the call on 05/29/14. The Dietician from the dialysis center indicated on 05/29/14 that patient number 2 was on a renal diet and 1500 ml (milliliter) fluid restriction. The Dietician also indicated the patient was not receiving meals on wheels but was receiving breakfast and lunch through a local agency in her apartment building. The dietician had indicated the social worker at the dialysis center was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 334	Continued From page 57	G 334		

concerned about the patient's ability to care for self due to patient had been disoriented and confused for a long period of time and was not able to comprehend simple directions.

2. Clinical record number 11, SOC 04/30/14, included a Comprehensive Non-Skilled Admission Assessment dated 4/30/14 that was incomplete and inaccurate. The assessment failed to indicate the reason for home health services; evidenced the patient had blurred vision but failed to evidence how the impaired vision interfered / impacted the patient's function / safety; pulmonary assessment evidenced the patient was receiving oxygen via nasal cannula at 3 liters per minute as needed but failed to evidence if there was humidification with the oxygen (nose assessment indicated the patient was having frequent nose bleeds) and failed to include intermittent treatments (duonebs nebulizer breathing treatments, albuterol inhalers, and flonase to each nostril); cardiac assessment failed to indicate if the patient had demonstrated / verbalized compliance with health education provided and the plan of care; nutritional assessment failed to evidence a weight and diet (renal diet), appetite was checked off as being "fair" but disease management stated, "Appetite poor;" neuro / emotional / behavior assessment failed to evidence the patient was receiving an antidepressant (paxil), the dose and frequency; safety measures had a diagonal line through the section and failed to indicate bleeding and fall precautions as well as walker / cane; allergies section was left blank; and failed to indicate if the patient had oxygen back up.

3. Clinical record number 12 included an OASIS Admission Assessment dated 03/21/14 that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 334	Continued From page 58	G 334		

failed to evidence the patient's name and identification number on pages 2 to 20; Medicare Number (M0060), Social Security Number (M0063); Emergency Triage Code; DNR order (obtained or requested); episode timing (M0110); Date of Physician-ordered start of care (M0102); inpatient diagnosis (M1010); Inpatient Procedure (M1012), incomplete history and diagnoses; a diagnosis for the anti-cancer medication (Amidex) (M1022); advance directives; how impaired vision interfered / impacted the patient's function / safety (M1200); and (M1242) a complete pain assessment. The endocrine assessment failed to indicate frequency of monitoring of blood sugars; competency assessment and disease management problems, anemia, and thyroid. The Integumentary status (M1302 and M1320) was incomplete; Diabetic foot exam indicated the patient assesses her feet daily but vision assessment (M1200) stated the patient was blind. The Cardiopulmonary assessment failed to include intermittent treatments such as medicated inhalation and disease management problems; Genitourinary (M1610) was checked off "no problem" but the plan of care stated "The patient will experience no areas of skin breakdown or redness due to incontinence. The Fall Risk assessment failed to indicate diagnosis of 3 or more, pain affecting level of function, incontinence, cardiovascular / respiratory disease, therefore changing the patients score of 20 to 40 (M1910) and Patient / Caregiver High Risk Drug Educations (M2010) indicated "N/A" (not applicable) when the patient had been receiving insulin (Novolog), 2 oral diabetic medications (glipizide and metformin), antiplatelet (plavix), diuretics / antihypertensive (hydrochlorothiazide), 4 antihypertensive medications (Verapamil ER, Lisinopril, Metoprolol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 334	Continued From page 59	G 334		

tartrate, and Losartan), anti-cancer drug (Amidex), and an anti-convulsant / mood stabilizer (Carbamazepine ER). Safety measures failed to indicated bleeding precautions; DME supplies failed to indicate all diabetic supplies; Summary checklist failed to identify duplicate drug therapy, and patient / caregiver education failed to indicate if the patient / caregiver appeared to understand all information given.

The OASIS Recertification Assessment dated 05/15/14 failed to evidence the patient's name and identification number on pages 2 to 14, physician identification and demographics (M0018); Patient ID (M0020); Medicare number (M0063); Social Security Number (M0064), Emergency Triage Code, DNR order (obtained or requested), episode timing (M0110); a diagnosis for the anti-cancer medication (Amidex) (M1022); Primary Caregiver / Supportive Assistance; and how impaired vision interfered / impact the patient's function / safety (M1200). The Diabetic foot exam indicated the patient assesses her feet daily but vision assessment (M1200) stated the patient was blind. The Cardiopulmonary assessment failed to include intermittent treatments such as medicated inhalation and disease management problems (M1400); Endocrine assessment failed to indicate frequency of monitoring of blood sugars. Genitourinary (M1610) was checked off "no problem" but the plan of care stated, "The patient will experience no areas of skin breakdown or redness due to incontinence." The Fall Risk assessment failed to indicate a history of falls in the last 3 months, pain affecting level of function, incontinence / urgency, and cardiovascular / respiratory disease, therefore changing the patient's score of 15 to 35 (M1910). Safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 334	Continued From page 60 measures failed to indicate bleeding precautions; summary checklist medication status check off "no change" in medications (4 new medication orders written 05/13/14). The assessment failed to address duplicate drug therapy and durable medical equipment supplies failed to indicate all diabetic supplies. 4. A policy titled "Initial & Comprehensive Assessments" dated 08/22/11 stated, "The assessment will be patient specific and comprehensive to include the patient's need for home care, rehabilitative care, social, and discharge planning needs ... During the initial and comprehensive patient assessment, all baseline data to be used in measuring the patient's progress toward goals and other relevant information will be documented in the patient's clinical record." 5. A policy titled "Reassessment / Recertification" dated 08/22/11 stated, "Document of changes in the patient's assessment findings ... Documentation in the clinical record should support the assessment as well as the actions taken in response ... "	G 334		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on clinical record and policy review and	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 61	G 337		

interview, the agency failed to ensure the medication profile was current and up to date for 2 of 4 records reviewed creating the potential to affect all of the agency's 21 current patients receiving services. (# 2 and 12)

Findings include:

1. Clinical record number 2, SOC 05/05/14, included a physician order dated 05/08/14 to increase the amlodipine from 5 mg (milligrams) to 10 mg. The medication profile failed to evidence the new dosage.

2. Clinical record number 12 included a skilled nurse visit note dated 04/17/14 tahat identified the patient was prescribed Carvidolol 3.125 mg (milligrams) 1 tab twice a day, Klor - Con M20 (potassium supplement) 20 meq (milliequivalent) ER (extended release) 1 tab daily with food, and hydrochlorothiazide 25 mg 1 tab daily. A physician order dated 05/13/14 was for Carvidolol 3.125 mg 1 tab by mouth twice a day, Klor-Con M20 20 meq ER 1 tab by mouth daily with food, and hydrochlorothiazide 25 mg 1 tab by mouth daily, and nitroglycerin 0.4 mg 1 tab every 5 minutes, maximum 3 tabs as needed for chest pain.

The medication profile failed to evidence the hydrochlorothiazide dosage had been increased and failed to include the nitroglycerin 0.4 mg 1 tab every 5 minutes up to 3 doses as needed.

3. The Director of Nursing, employee B, was unable to provide any additional documentation and/or information when asked on 05/28/14 at 12:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157641	A. BUILDING _____ B. WING _____	R-C 05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALCO HEALTHCARE SERVICES INC	1050 E 86TH ST ,SUITE 55-B INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	Continued From page 62 4. A policy titled "Reassessment / Recertification" dated 08/22/11 stated, "Drug regimen review of all medications for drug interactions, potential adverse effects and drug reactions, duplicative drug therapy, ineffective drug therapy, significant side effects, significant drug interactions ... "	G 337		